

Employee/Dependent Name _____ Address _____ Phone _____ Employee # _____	<div style="text-align: center;">SELECTED HEALTH PLAN OPTION</div> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Plan: EPO <input type="checkbox"/> RAN/AMN <input type="checkbox"/> Schaller Anderson Healthcare <input type="checkbox"/> United HealthCare PPO <input type="checkbox"/> AZ Foundation <input type="checkbox"/> United HealthCare <input type="checkbox"/> Beech Street </td> <td style="width: 50%; vertical-align: top;"> Additional Retiree Options – Over 65: <input type="checkbox"/> United HealthCare <input type="checkbox"/> PacifiCare </td> </tr> </table>	Plan: EPO <input type="checkbox"/> RAN/AMN <input type="checkbox"/> Schaller Anderson Healthcare <input type="checkbox"/> United HealthCare PPO <input type="checkbox"/> AZ Foundation <input type="checkbox"/> United HealthCare <input type="checkbox"/> Beech Street	Additional Retiree Options – Over 65: <input type="checkbox"/> United HealthCare <input type="checkbox"/> PacifiCare
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*You should apply for TOC assistance if you answer “Yes” to any question below,
Even if your doctor is participating in your new network.*

TRANSITION OF CARE FORMS

Please provide complete information to assure timely administration of TOC. Information provided will not cause medical plan enrollment denial. This information is for the Transition Team and your Health Plan only. This information will not be shared with your employer.

Please fill out a separate request form for each covered member:

PLEASE CHECK ALL THAT APPLY

- | | | |
|---|------------------------------|-----------------------------|
| Have you received or been evaluated for a transplant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you in the last 6 months of pregnancy or did you deliver less than 6 weeks ago? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had a “High Risk Pregnancy”? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently undergoing radiation or chemotherapy for cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you undergoing active treatment for Immunosuppressive Disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you being actively treated for severe or end stage kidney disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you currently undergoing dialysis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any procedure/surgery performed during the last 6 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any procedure/surgery scheduled in the next 3 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been hospitalized in the past 6 weeks? Please check below. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Hospital. If yes, Discharge date _____ | | |
| <input type="checkbox"/> Skilled Nursing Facility. If yes, Discharge date _____ | | |
| <input type="checkbox"/> Behavioral Health/Substance Abuse center. If yes, Discharge date _____ | | |
| <input type="checkbox"/> Acute Rehabilitation center. If yes, Discharge date _____ | | |
| Are you under the care of Hospice? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you receiving any of the following therapies either in your home or as an outpatient: Physical Therapy, Occupational Therapy or Speech Therapy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you receiving Home Health care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you receiving home IV infusion or outpatient infusion therapies,
for example, blood transfusions or antibiotic therapy? ☐ Yes ☐ No

Are you using any DME (Durable Medical Equipment), for example, wheelchair,
walker, crutches, oxygen, B-Pap machine, SVN breathing machine? ☐ Yes ☐ No

Are you currently assigned to a Case Manager? (Check below) ☐ Yes ☐ No

☐ Medical Case Management ☐ Behavioral Case Management

Are you being treated for a worker's compensation injury? ☐ Yes ☐ No

Are you receiving treatment for behavioral health/substance abuse issues? ☐ Yes ☐ No

Are you receiving anticoagulant (blood thinner) therapy? ☐ Yes ☐ No

Are you currently under the care of a physician for any of the following conditions or have you been diagnosed with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> MS (Multiple Sclerosis) |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> ALS (Amyotrophic Lateral Sclerosis-
Lou Gehrig's Disease) |
| <input type="checkbox"/> CHF (Congestive Heart Failure) | <input type="checkbox"/> CP (Cerebral Palsy) |
| <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary
Disease) | <input type="checkbox"/> Autoimmune Diseases |
| <input type="checkbox"/> CAD (Coronary Artery Disease) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> A-Fib (Atrial Fibrillation) |
| <input type="checkbox"/> CVA (Cerebral Vascular Accident) | <input type="checkbox"/> Eye diseases/Glaucoma |
| <input type="checkbox"/> TIA (Transient Ischemic Accident) | |
| <input type="checkbox"/> HTN (Hypertension) | |
| <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Other | |

For every item that you marked please supply the following information:

Condition / Date Treatment Started / Dr. Name & Address / Dr. Phone Number

Example: Asthma / Jan 1999 / Dr. Jones, 1234 E Any Street / 602-789-1234

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Employee #

Med Name	Pharmacy Name	Location	Phone